the Trent Faculty that a document from the Education Committee had been approved by Council for consideration by other educational bodies.

This document is reported to suggest that in future a wider range of posts should be considered appropriate for vocational training for general practice.

Our Faculty disagrees with the suggestion that more surgical posts should be recognised and rejects the idea that six months' senior house officer experience in specialities such as neurosurgery or thoracic surgery should be approved for general-practice training.

Furthermore the inclusion of such posts is likely to mean in practice that other much more important specialities such as: general medicine, paediatrics, geriatrics, obstetrics, and gynaecology will be squeezed out of many trainees' programmes.

We regard this as a serious dilution of the standards that the Royal College of General Practitioners should be maintaining and we fully support the Trent Faculty's concern.

We request Council to revert as soon as possible to the previously agreed policy on the recognition of posts for vocational training and urge those who support us to write to Council as well.

J. F. BURDON
Chairman
South-west England Faculty Board

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TWO TYPES OF TRAINING

Sir,

As a " second class citizen ", but none the less occasional reader of your *Journal*, your February editorial, *Two types of training*, prompts me to comment that it is a pity that the College, in re-affirming its concern not to make those who have not completed full vocational training programmes feel " second class citizens ", continues to ostracise those of us who have voluntarily completed a trainee year by refusing to let us sit its entrance examination, simply because we lack sufficient approved hospital experience.

I feel that this is particularly so since (a) the matter of exactly what constitutes relevant and necessary hospital experience at present still remains open to question, and (b) the minimum requirement for entering practice as a principal, at least in the forseeable future, is simply the completion of a trainee year. This will continue at least until the 1980s, when there is still no mention of any particular hospital experience required. In the meantime, those of us who have compromised by voluntarily completing a trainee year before entering practice, though lacking the so-called " necessary, relevant " experience, remain frustrated from taking our enthusiasm further for at least another couple of years, simply because we lack a spurious amount of relevant experience. It makes one wonder, why one troubled to do a trainee year, since having done so one is in no better position to take the College's entrance examination than if one had not bothered and had gone straight into practice and bided one's time until one was eligible to sit the examination.

Has the College considered the implications of allowing doctors to sit the examination after completing only a trainee year? If the examination is, as it claims to be, merely a test of competence then, although some general-practitioner experience is clearly desirable, the necessity of other experience remains questionable, for surely competence varies from individual to individual rather than according to length of experience?

One can only assume that the College's obsession with perpetuating the myth of the apprenticeship scheme as being the only method of learning is to fall into line with the other, older-established Colleges, whose commitment to this system stems mainly from the desire to maintain their own elitism. If this is the case, then it is clearly totally out of keeping with the otherwise progressive image of the College in trying to raise the overall standard of general practice.

In the meantime, there must be a number like myself, " on the outside ", doing basically the same job of work as those " on the inside " but without " the badge ", and I wonder if really we are doing the job that much worse?

The only way to find out seems to me to be for the College to be prepared to open its doors wider to admit some of us " second class citizens ", for simply to go on pretending that we are not inferior in the eyes of the College seems to me to do no more than to add further insult to the already existing injury.

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REFERENCE

Journal of the Royal College of General Practitioners (1976). Editorial, **26**, 83–4.

WHEN NOT TO EXAMINE PATIENTS

Sir,

I should be interested to hear other views on constructing a suitable ' milieu ' in which the ordinary consultation in general practice may proceed scientifically.

My trainer taught me that the examination of a frightened, sick, young child should be kept to a minimum. This was coupled with the positive suggestion that friendship with the child was of paramount importance, and that at no stage should rapport be lost (Colston, 1975).

It is plain that the highest scientific standards of clinical examination in childhood can be achieved only with co-operation from patients. Such standards are essential in the case of complex or dangerous disease. It is bad scientific practice

to upset the frightened with infective ear-ache by examining the ear against their will. Is it good scientific practice only to befriend and prescribe antibiotic on that particular occasion, so that future consultations are characterised by friendship, and co-operation, with subsequently higher standards?

This concept of foregoing immediate scientific satisfaction in favour of a future high-standard ' atmosphere ' is illustrated again by the recently-registered, neurotic, elderly patient. Such a patient arrives from her previous doctor with a string of medications upon which she (or he) is allegedly dependent. A wise (and scientific) doctor will refrain from changing the drugs until such a time as rapport has been achieved. This may mean prescribing a host of slimming tablets, sleeping tablets, nerve tablets and tonics until a working relationship has been established.

Of course, friendliness, toys, business-like efficiency, and helpful consultants and hospitals all go toward the establishment of confidence and trust by the patient in their family doctor. But should we avoid rectal and vaginal examinations for such reasons? To what extent do we give in to patients' pressures and wishes, and to what extent is it in their present or ultimate interests?

I should like to know what techniques are employed by doctors to achieve long-term scientific satisfaction, and to what extent the short-term diagnostic and therapeutic measures are thereby compromised.

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REFERENCE

Colston, B. (1975). Personal communication.

FALSE URINARY INFECTIONS FROM DIP-SLIDE CULTURES

Sir,

During 1975 in our laboratory there was an apparent increase in the percentage of antenatal urinary infections (bacteriuria $\geq$50,000 organisms/ml) due to gram-positive organisms; this rose from 22 per cent of 164 infected urines in 1974 to 42 per cent of 253 in 1975. The most frequent gram-positive organism isolated was *Staphylococcus albus*: from 11 per cent of apparent urinary infections in 1974 and 26 per cent in 1975. *Micrococcus Subgroup 3*, a recognised urinary pathogen, was separately identified from a further three per cent of infections in 1975.

The apparent increase in number of *Staph. albus* infections coincided with an increased use of dip-slide cultures. Since this organism is a commensal of the normal urethra, we suspected that these dip-slide cultures had been taken from early-stream urines instead of mid-stream urines. Therefore, when a significant bacteriuria was found, a repeat dip-slide culture was requested, the importance of the use of mid-stream urine for the dip-slide sample being emphasised.

Of 31 women whose first dip-slide showed significant *Staph. albus* bacteriuria, 28 had sterile urine or insignificant *Staph. albus* bacteriuria in the second dip-slide. Information concerning treatment of the infection with antibotics was available for only 14 of these 28; ten of the 14 had received no antibotic therapy and all ten showed sterile second urine specimens; two women had inappropriate therapy (nalidixic acid to which the *Staph. albus* was resistant) and their repeat dip-slides were also sterile; the remaining two women had sterile urine after appropriate antibiotic therapy.

These findings suggest that some so-called urinary infections due to *Staph. albus* are in fact due to skin or urethral contamination. This emphasises the importance of instructing nursing staff and patients in the necessity of holding the dip-slide in mid stream urine.

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MATHEMATICAL MODELS OF GENERAL PRACTICE

Sir,

I agree with Dr Russell that the negative binomial provides a better fit to the distribution of episodes in general practice. I discovered this when I attempted to apply the geometric distribution to the episode frequencies recorded by separate practices. This work will be described in a paper to be printed in the *Journal of the Royal Statistical Society-C (Applied Statistics)*. Dr Crombie has, however, pointed out to me that there are certain practices in which even the negative binomial does not fit the distribution of episodes.

The reasons for this are unclear at this time.

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Crombie, D. (1976). Personal communication.

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WHAT KIND OF PRACTICE

Sir,

I am concerned, as a recent recruit to general practice, that despite the enormous strides the